Washington State Department of Social & Health Services
ADSA Aging & Disability Services Administration

LEVEL 1 PRE-ADMISSION SCREENING AND RESIDENT REVIEW (PASRR)

NAME	
STREET ADDRESS	
CITY	STATE ZIP CODE
SOCIAL SECURITY NUMBER	DATE OF BIRTH (MM/DD/YYYY)

The identification screen applies to all persons being admitted to or residing in Medicaid Certified Nursing facilities

For a new admission, indicate the date of the request for admission:	For a current resident, indicate the date of admission:

SECTION I – MENTAL ILLNESS/DEVELOPMENTAL DISABILITY DETERMINATION

A. Mental Illness Indicators

Has the individual shown indicators within the last two years of having any of the following mental disorders? If yes, check the appropriate area below. If known, write in the appropriate code using the Diagnostic and Statistical Manual (DSM IIIR or IV).

	Yes	No		Yes	No
Schizophrenic Disorders (295.XX)	☐	☐	Psychotic Disorder NOS (298.9)	☐	☐
Mood Disorders – Depressive or Bipolar (293.83; 296.XX; 311)	☐	☐	Anxiety Disorders (293.89; 300.XX)	☐	☐
Delusional Disorder (297.1)	☐	☐	Personality Disorders (limited to 301.0; 310.1; 301.22; 301.4; 301.83)	☐	☐

B. Developmental Disability Indicators

	Yes	No
1. Does the individual have documented evidence of a diagnosis of a developmental disability (onset occurred before age 22)?	☐	☐
2. Is there any history of a developmental disability in the individual's past (onset occurred before age 22)?	☐	☐
3. Did an agency or facility that serves individuals with developmental disabilities refer the individual?	☐	☐

If any of the answers in Part A or Part B are Yes, complete Sections II and III. If all of the answers in Part A and Part B are No, complete only Section III.

SECTION II – ADVANCED CATEGORICAL DETERMINATIONS

☐	30-day care: Person requires convalescent nursing home care following treatment in an acute care hospital, or person is being admitted for respite care, as defined in WAC 388-97. Physician must verify that care will not exceed 30 days.
☐	Terminal Illness: The person's attending physician has certified an explicit terminal prognosis prior to placement and whose life expectancy is less that 6 months.
☐	Delirium: The person has a primary diagnosis of delirium as defined in the Diagnostic and Statistical Manual of Mental Disorders.
☐	Severe Medical Condition: The person has a medical condition at a severe level that prevents him/her from participating in specialized services. (e.g. coma, ventilator dependence, etc.)
☐	Dementia: The person has a primary diagnosis of dementia as defined in the Diagnostic and Statistical Manual of Mental Disorders. Attached is a copy of the person's comprehensive history and physical examination which supports the diagnosis.

If any of the above boxes are checked, the person may enter or remain in the NF without a Level II evaluation. Attending physician must approve and sign for any categorical determinations.

PHYSICIAN'S SIGNATURE _____ DATE _____

SECTION III – SERVICE NEEDS AND ASSESSOR DATA

☐ **No Level II Evaluation required** - Person does not show indicators of MI or DD or is exempt because of an advanced categorical determination.

☐ **Level II Evaluation required** - Person shows indicators of MI or DD and does not fit any of the advanced categories. (Contact the local HCS office.

NAME/TITLE OF PERSON COMPLETING THIS FORM (PLEASE PRINT)	NAME OF AGENCY	DATE

ADDRESS	CITY	STATE	ZIP CODE	TELEPHONE NUMBER

DISTRIBUTION: White – Nursing Facility Yellow – Person Completing Form

LEVEL I PRE-ADMISSION SCREENING AND RESIDENT REVIEW – INSTRUCTIONS

WHAT IS THE PURPOSE OF THIS FORM?

The federal Omnibus Budget Reconciliation Act (Public Law 100-203) requires that all individuals applying for or residing in a Medicaid-certified facility be screened to determine whether they:

1. Have a serious mental illness, a developmental disability, or mental retardation; and if so,
2. Require the level of services provided by a nursing facility; and
3. Require specialized services (e.g. psychiatric hospitalization).

WHO MAY COMPLETE THIS FORM?

For individuals applying for admission, the attending physician or his/her medical staff, an HCS (Home and Community Services Case Manager, an AAA (Area Agency on Aging) Case Manager, or a DDD (Division of Developmental Disabilities) Case Manager may complete this form.

The nursing facility is responsible for assuring that the form is complete and accurate at the time of, or before, admission. The NF must maintain and update this form as necessary.

SECTION I – MENTAL ILLNESS/DEVELOPMENTAL DISABILITY DETERMINATION

Serious Mental Illness (MI): An individual who has a primary or secondary diagnosis of mental disorder (as defined in the Diagnostic and Statistical Manual of Mental Disorders, 3rd edition) and does not have a primary diagnosis of dementia (including Alzheimer's disease or a related disorder). In addition, the individual's level of symptoms is severe and meets the criteria for (1) serious functional impairment from mental illness, and (2) more than routine level of psychiatric treatment.

Developmental Disability (DD): An individual with mental retardation or related condition.
Mental Retardation and Related Conditions: An individual is considered mentally retarded if the individual has a level of retardation (mild, moderate, severe, and profound) as described in the American Association on Mental Deficiencies Manual of Classification of Mental Retardation (1983). Mental retardation refers to significantly sub-average general intellectual functioning existing concurrently with deficits in adaptive behavior and manifested during the developmental period.

Persons with related conditions: Individuals with a severe, chronic disability whose conditions:

1. Are attributable to:
    a. Cerebral palsy or epilepsy;
    b. Any other condition, other than mental illness, found to be closely related to mental retardation which results in impairment of general intellectual functioning or adaptive behavior similar to that of a person with mental retardation, and requires treatment or services similar to those required for these persons (e.g. autism).
2. Manifested before the age 22.
3. Are likely to continue indefinitely.
4. Results in substantial functional limitation in 3 or more areas of major life activity (i.e. self care, communication, learning, mobility, self-direction, and capacity for independent living).

SECTION II – ADVANCED CATEGORICAL DETERMINATIONS

Per 42 C.F.R. §483.130, advanced categorical determinations may be applied to exempt individuals from a Level II evaluation. Use supporting documents to determine if the individual fits one of the advanced categories. The attending physician must approve and attach any necessary supporting documents. The NF may complete this section for residents who have shown a significant change before referring the resident to HCS.

SECTION III – SERVICE NEEDS AND ASSESSOR DATA

No Level II evaluation required – Medicaid clients, who do not require a Level II evaluation, still need to be assessed of their need for nursing facility level of care. Contact HCS to complete this assessment. All other persons may enter the nursing facility following regular admission procedures.
Level II Evaluation required – Contact HCS to assess whether the person needs the nursing facility level of care. HCS will then arrange for a MH agent or a DDD agent to complete the Level II evaluation. At the Level II, the agent determines the severity of symptoms and the need for specialized services.

QUESTIONS?

If you have questions regarding the Pre-Admission Screening and Resident Review program, call 1-800-422-3263. To order more Pre-Admission Screening forms, e-mail fulfillment@prt.wa.gov , fax your order to Department of Printing at (360) 586-6361, or visit the Forms & Records Management website at www.wa.gov/dshs/dshsforms/forms/eforms.html .